| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | N089063 | A. BUILDING: _____ B. WING _____ | C 11/12/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ATRIA HEARTHSTONE EAST | 3415 SW 6TH AVE TOPEKA, KS 66606 |

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| S 000 | INITIAL COMMENTS<br><br>The following citations are the result of a Licensure Resurvey at the above named Assisted Living Facility in Topeka, Kansas on 11/03/14, 11/04/14, 11/05/14, 11/06/14, 11/10/14, and 11/12/14. Complaint #80821 also investigated. Revised 2567 mailed to facility 11/19/14. | S 000 | | |
| S3028 SS=F | 26-41-101 (f) (3) Staff Treatment of Residents Reporting<br><br>(f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met:<br>(A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation.<br>(B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress.<br>(C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator.<br>(D) Appropriate corrective action shall be taken if the alleged violation is verified.<br>(E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report.<br>(F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. | S3028 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| S3028 | Continued From page 1<br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-101(f)(3)(C)(E)(F)<br><br>The census equalled 88 the sample included six, five current Residents and one discharged Resident, with three focused reviews completed. Based on interview and record review, for three of three focused reviews (#180, #181, and #182), the Administrator failed to ensure an investigation completed and submitted to the Department within five working days of a reported incident; and failed to ensure a written record maintained of each investigation, in order to rule out Resident abuse or neglect.<br><br>Findings Included:<br><br>- Record review of facility investigation #8342 revealed #180 was found on floor 8/12/14 at 10:30pm and was unsure of how he/she fell. #180 had pain in left leg, and ambulance transported to the hospital. Resident found to have a left hip fracture, and surgery done on 8/13/14.<br><br>Facility record revealed #180 admitted 7/14/14 with diagnoses of Dementia and Fracture of Left Humerus.<br><br>7/15/14 FCS (functional capacity screen) assessed #180 with need for physical assistance with bathing and dressing, unable to perform medication and treatment management; in need of supervision with eating and mobility; independent with toileting and transfers; with short term memory, memory recall, and decision making impairments; and usually continent.<br><br>7/14/14 NSA (negotiated service agreement) documented #180 to receive assistance with | S3028 | | |

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| S3028 | Continued From page 2 | S3028 | | |

bathing, dressing, medications; escorted to meals and activities; to have hourly safety checks; and to receive OT/PT (occupational therapy/physical therapy).

Resident Progress Notes documented the following:

8/13/14 - 4:01 p.m "Fax sent to physician... on 8/12/14 at 1030pm staff noted Resident on the floor face down in apartment... Resident unsure of how he/she fell... nurse on duty came to assess... pain in left leg... EMS (emergency medical services) transported to hospital... surgery for left hip fracture..." by licensed nurse #F

Department documentation indicated facility reported incident on 8/15/14, with the facility investigation due on 8/22/14. Department notified facility on 9/16/14, 10/07/14, and 10/16/14 that the facility report had not been received.

By review on 11/05/14, report #8342 lacked details of an assessment of Resident's condition, statements of staff and other potential witnesses, and documentation of investigative steps taken to rule out abuse or neglect of Resident.

By interview on 11/05/14 at 1:30pm, Administrator and Life Guidance Care Coordinator #D stated we do not keep the "paper assessments"... basically when some one falls we do a head to toe/ROM (range of motion)/pain or discomfort assessment... if they have pain we call EMS... in injury above first aide, call EMS.

On 11/05/14 at 6:12pm, Administrator and Life Guidance Care Coordinator #D confirmed no other documentation or investigation completed,

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| S3028 | Continued From page 3<br>nor submitted to Department.<br><br>The Administrator failed to ensure an investigation completed and submitted to the Department within five working days of this reported incident for #180, and failed to ensure a written record maintained of the investigation completed to rule out Resident abuse or neglect.<br><br>- Record review of facility investigation #8343 revealed #181 was found at 10th and Oakley by a neighborhood professional, and returned to facility on the morning of 8/13/14. Resident not aware of where he/she was and unable to find way home... #181 put on immediate one to one observation by nurse... family notified... family stayed with #181 until transportation to a diagnostic unit at the hospital... evaluation and found to be unsafe in a facility without secure doors... #181 admitted to Life Guidance Center.<br><br>Facility record revealed #181 admitted with diagnosis of Dementia.<br><br>Department documentation indicated facility reported incident on 8/15/14, with the facility investigation due on 8/22/14. Department notified facility on 9/16/14, 10/07/14, and 10/16/14 that the facility report had not been received.<br><br>By review on 11/05/14, report #8343 lacked details of an assessment of Resident's condition, statements of staff and other potential witnesses, and documentation of investigative steps taken to rule out abuse or neglect of Resident.<br><br>On 11/05/14 at 6:14pm, Administrator, Assisted Living Care Coordinator #F, and Life Guidance Care Coordinator #D confirmed no incident report | S3028 | | |

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| S3028 | Continued From page 4 | S3028 | | |

or additional investigation completed... Administrator stated everyone knew I was reporting this to Department... I put everything I would of put on an incident report in the investigation sent to Department... nothing else for that one...

The Administrator failed to ensure an investigation completed and submitted to the Department within five working days of this reported incident for #181, and failed to ensure a written record maintained of the investigation completed to rule out Resident abuse or neglect.

- Record review of facility investigation #8695 revealed #182 was found on floor with laceration to head on 8/22/14... was unsure of how he/she fell. #182 was transported to the hospital and did not return to facility.

Review of record revealed #182 admitted to facility 12/04/12 with diagnoses of Alzheimer's dementia, Depression, and Hypertension.

The 6/21/14 FCS (functional capacity screen) assessed #182 in need of physical assistance with bathing, dressing, toileting, and eating; in need of supervision with transfers and mobility; unable to perform medication and treatments; with impaired communication, incontinence, short term memory, long term memory, memory recall, decision making, with falls/unsteadiness, and used a wheelchair.

The 5/20/14 NSA (negotiated service agreement) documented #182 to receive staff assistance with grooming, bathing, dressing, eating, medications, incontinence care, escort to meals, and status checks hourly.

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| S3028 | Continued From page 5<br><br>Resident Progress Notes included the following:<br><br>8/24/14 - 10:00am "Fax sent to physician: please note on 8/22/14 at approximately 7:30pm found Resident on floor in the bathroom doorway... when asked what happened there was no response... was moving around trying to get up and bleeding from left eyebrow... called EMS (emergency medical services), family notified... admitted for left frontal lobe bleed..." by licensed nurse #H.<br><br>Department documentation indicated facility reported incident on 8/26/14, with the facility investigation due on 9/03/14. Department notified facility on 9/29/14 the submitted report determined incomplete, with additional information requested. Department notified facility on 10/14/14 of the additional documents needed to complete the report.<br><br>By review on 11/05/14, report #8695 lacked details of an assessment of Resident's condition, statements of staff and other potential witnesses, and documentation of investigative steps taken to rule out abuse or neglect of Resident.<br><br>By interview on 11/05/14 at 12:29pm Administrator and Life Guidance Care Coordinator #D confirmed no other investigation information or documentation available.<br><br>The Administrator failed to ensure an allegation of abuse or neglect was reported to the department within 24 hours, an investigation completed and submitted to the Department within five working days of this reported incident for #182, and failed to ensure a written record maintained of the | S3028 | | |

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| S3028 | Continued From page 6<br>investigation completed to rule out Resident abuse or neglect. | S3028 | | |
| S3105 SS=D | 26-41-202 (j) Negotiated Service Agreement Outside Resource<br><br>(j) If a resident's negotiated service agreement includes the use of outside resources, the designated facility staff shall perform the following:<br>(1) Provide the resident, the resident's legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family, with a list of providers available to provide needed services;<br>(2) assist the resident, if requested, in contacting outside resources for services; and<br>(3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-202(j)<br><br>The census equalled 88 the sample included six, five current Residents and one discharged Resident, with three focused reviews completed. Based on observation, interviews, and reviews of records, for one of six sampled (#185), the Administrator failed to ensure designated facility staff monitored the services provided by outside resources and acted as an advocate for the Resident.<br><br>Findings included: | S3105 | | |

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| S3105 | Continued From page 7<br><br>- Review of record revealed #185 admitted to facility 3/23/07 with diagnoses of Depression, Hypertension, Gastroesophageal reflux disease, Indigestion, Pain, Anxiety, Constipation, and Anemia.<br><br>8/13/13 - FCS (functional capacity screen) coded #185 in need of physical assistance with bathing, dressing, toileting, transfers, mobility; use of wheelchair; experienced impaired short term memory and memory/recall; unable to perform medication and treatment management; with bladder incontinence, falls and unsteadiness.<br><br>10/21/14 and 7/23/14 - NSA (negotiated service agreement) documented facility staff provide bathing assistance on Friday only, and Hospice to assist with one shower a week.<br><br>10/21/14 and 7/23/14 - Comprehensive Plans - facility staff to assist with bathing on Fridays... outside services by Hospice to include bathing each week.<br><br>By observation and interview on 11/05/14 at 9:36am, #185 wearing stained clothing and a discernable odor of stale urine and stale clothing noted... #185 stated shower not a regular thing... maybe one time a month... nobody else helps me with a shower...<br><br>On 11/05/14 at 4:31pm and 4:38pm, Assisted Living Care Coordinator #F stated I don't know what the outside provider Hospice care giver did yesterday... I will talk with them about putting papers in notebook every day... no really monitoring if we don't know when or what they are doing for sure... no way of showing we are monitoring them (outside provider Hospice)... sometimes they stick head in the medication | S3105 | | |

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| S3105 | Continued From page 8<br>room and sometimes they leave a yellow care progress note... that's not good enough...<br><br>By review of Hospice care progress notes and facility task documentation for August, September, and October 2014, bathing assistance provided:<br><br>Documented Resident #185 as "refused" for Hospice bathing assistance 11 times (8/07, 13, 15, 22, 26, 9/02, 12, 19, 26, 10/14, 24, 10/30/14).<br><br>Documented Resident #185 as bathing assistance by both facility staff and Hospice staff on 8/01/14, 8/29/14, and 10/17/14.<br><br>By interview on 11/05/14 at 4:31pm, Assisted Living Care Coordinator #F stated I was not aware #185 refused or didn't receive showers from Hospice on all those occasions... I guess on some days both gave him/her a shower... I am not real sure what day of the week each is to provide the service...<br><br>The Administrator failed to ensure designated facility staff monitored the services provided to #185 by an outside resource and acted as an advocate for the Resident. | S3105 | | |
| S3155 SS=F | 26-41-204 (a) Health Care Services<br><br>. (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. | S3155 | | |

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| S3155 | Continued From page 9 | S3155 | | |

This REQUIREMENT is not met as evidenced by:
KAR 26-41-204(a)

The census equalled 88 the sample included six, five current Residents and one discharged Resident, with three focused reviews completed. Based on observation, interview, and reviews of records, for five of six sampled (#189, #187, #185, #184, and #186), the Administrator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of each Resident.

Findings included:

- Review of record revealed #187 admitted to facility 6/06/14 with diagnoses of Alzheimer's, Hypertension, Urinary tract infection, and Mood disorder.

10/02/14 FCS (functional capacity screen) coded #187 in need of supervision with bathing, dressing, toileting; unable to perform medication and treatment management; impairment of short term memory, long term memory, decision making and memory recall; and identified wandering as a current or recent problem.

10/02/14 NSA (negotiated service agreement)/health care service plan (HSP) documented staff to assist with bathing, medications, escort to and from meals/activities, occasional observations for safety and interactions with others; staff to observe condition every hour, status checks due to diagnosis of

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| S3155 | Continued From page 10 | S3155 | | |

dementia.

Resident Progress Notes documented the following:

10/02/14 12:30pm - arrived to community (from hospitalization)... alert, oriented per his/her norm... Fall screen completed and the following interventions put into place: assess Resident's room for pathway obstruction from bed to bathroom, encourage participation in daily activities, and ensure Resident has proper footwear.

The NSA/HSP lacked documentation of interventions to address risks for falls.

Resident Progress Notes contained the following:

Entry created on 10/20/14 at 9:47 describing 10/17/14 incident: "At approximately 11:15am care staff went to check on Resident in his/her room... observed on the floor lying on right side... this nurse called to assess... Blood Pressure 132/86 Pulse 72 Respirations 20... was assisted up 2:1... Resident had no noted injuries at the time... Resident did complain of right arm pain... upon assessment Resident had good ROM (range of motion) in all extremities... Resident assisted with dressing, and ambulated to the dining room without difficulty... family and physician notified of incident... " by licensed nurse #D

Resident #187's FCS identified wandering as a current or recent problem and the nursing assessment at the time of readmission documented the resident at risk for falls. The

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| S3155 | Continued From page 11<br>NSA/HSP lacked interventions to address wandering and risk for falls.<br><br>For Resident #187, the Administrator failed to ensure the licensed nurse provided and coordinated the provision of necessary health care services to meet the needs of this Resident related to risk for wandering and falls.<br><br>- Review of record revealed #185 admitted to facility 3/23/07 with diagnoses of Depression, Hypertension, Gastroesophageal reflux disease, Indigestion, Pain, Anxiety, Constipation, and Anemia.<br><br>8/13/13 - FCS (functional capacity screen) coded #185 in need of physical assistance with bathing, dressing, toileting, transfers, mobility; use of wheelchair; experienced impaired short term memory and memory/recall; unable to perform medication and treatment management; with bladder incontinence, and identified falls and unsteadiness as a current or recent problem.<br><br>7/23/14 and 10/21/14- NSA (negotiated service agreement)/health care service plan (HSP) documented #185 to have staff assistance with bathing, dressing, medication/treatment management, toileting/incontinence; and escort or assist to/from meals. The NSA/HSP lacked interventions to address risk for falls<br><br>7/23/14 and 10/21/14 - Comprehensive Plans - documented facility staff to assist with wheelchair mobility, bathing on Fridays, toileting, dressing, and medication assistance; encouraged to use call pendant if needs assistance transferring to prevent falls; care staff will remind to use pendant to assist in the prevention of falls. | S3155 | | |

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| S3155 | Continued From page 12<br><br>Resident Progress Notes (RPN) documented the following<br><br>Resident found on the floor when attempted to transfer self between bed and wheel chair on 4/5/14, 4/9/14, 5/3/14, 6/1/14, and 6/20/14.<br><br>7/26/14 1:19 a.m. "Fax placed in [physician] folder: on 7/23/14 at approximately 6:45am Resident pushed lifeline (pendant), care staff to assist... on floor next to bed... stated fell out of bed, denies hitting head, no complaints of pain... assisted up 2:1 into bed... "Intervention: Resident to use pendant prior to getting out of bed"... by Licensed nurse #H<br><br>9/01/14 - 0545 "CMA (certified medication aide) entered room... on floor... did not know how he/she got there... nurse notified, no injuries noted... assisted 3:1 into wheelchair..." by licensed nurse #F<br><br>Resident #185's FCS identified him/her at risk for falls and the resident progress notes documented multiple falls. The NSA/HSP lacked interventions and revisions to address the ongoing risk for falls.<br><br>For Resident #185, the Administrator failed to ensure the licensed nurse provided and coordinated the provision of necessary health care services to meet the needs of this Resident related to risk for falls.<br><br>- Review of record revealed #184 admitted to facility 11/15/13 with diagnoses of Dementia, | S3155 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ATRIA HEARTHSTONE EAST | 3415 SW 6TH AVE TOPEKA, KS 66606 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| S3155 | Continued From page 13<br>Depression, Neuropathy, Osteoarthritis, Hypoglycemia, and Buttock wound.<br><br>11/15/13 - FCS (functional capacity screen) coded #184 in need of physical assistance with bathing, dressing, toileting; supervision with transfers and mobility; unable to perform medications or treatments; with bladder incontinence; experienced impaired long term memory, short term memory, memory/recall, and decision making; and identified falls and unsteadiness as a current or recent problem or risk.<br><br>9/10/14 NSA (negotiated service agreement)/health care service plan (HSP) documented #184 to have staff assistance with grooming, assistance with bathing and dressing, and medications; reminders for toileting, assistance with orientation/memory; observe Resident's condition every hour...requires hourly safety checks due to dementia diagnosis...<br><br>9/10/14 Comprehensive Plan documented #184 used walker for mobility with staff supervision at times; requires hourly safety checks due to dementia diagnosis...<br><br>Resident Progress Notes (RPN) documented the following :<br><br>11/15/13 - 6:39pm - "arrived at community at 4pm... alert and oriented and has full range of motion... no skin issues... Fall screen completed and the following interventions put into place: assess Resident's apartment for any pathway obstructions, encourage participation in daily activities and ensure Resident has proper footwear." by licensed nurse #F | S3155 | | |

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| S3155 | Continued From page 14<br>6/06/14 - 2:20pm - "staff entered room to prepare him/her for an activity... found sitting on floor... states fell, no pain... nurse came to assess, found no injuries... will continue to monitor..".<br><br>6/19/14 10:01 a.m. " on 6/18/14 at 7:15pm staff assisting Resident out of the shower, stepped on bathroom rug and started to slip... staff eased down... nurse on duty came to assess... scratch on abdomen, no complaint of pain... bathroom rug removed... the following interventions put into place: remove bathroom rug and apply non-skid strips in the bathroom..." by licensed nurse #D<br><br>On 11/05/14 at 9:56am and at 11:00am, observed #184 ambulating independently with roller walker to an activity, cued by care staff.<br><br>On 11/05/14 at 11:00am, direct care staff #J stated #184 likes to do as much as possible for self... not many falls... uses walker<br><br>Resident #184's FCS identified him/her at risk for falls, the Licensed nurse identified Resident #184 as a fall risk based on the fall screen at time of admission and the resident experienced two falls after admission. The NSA/HSP lacked documentation of interventions to address risk for falls.<br><br>For Resident #184, the Administrator failed to ensure the licensed nurse provided and coordinated the provision of necessary health care services for this Resident, when the licensed nurse failed to implement interventions to address fall risk. | S3155 | | |

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| S3155 | Continued From page 15<br><br>- Review of record revealed #189 admitted to facility 8/20/14 with diagnoses of Dementia, Malaise, and Total hip replacement.<br><br>8/20/14 FCS (functional capacity screen) assessed #189 in need of physical assistance with bathing, dressing, toileting; supervision with transfers and mobility; unable to perform medication and treatment management, with incontinence, used walker and wheelchair; cognitive impairments for short term memory, long term memory, decision making, and memory recall and identified falls/unsteadiness as a current or recent problem or risk.<br><br>8/20/14 NSA (negotiated service agreement)/Health care service plan (HSP) documented #189 to receive staff assistance with bathing, dressing, grooming, medications, toileting, escort to meals, and supervision with transfers. The NSA documented staff to observe #189's condition every hour... hourly safety checks due to dementia diagnosis.<br><br>Resident Progress Notes (RPN) documented :<br><br>8/20/14 at 3:45pm, "arrived to community... alert and oriented, no complaint of pain... lifeline pendent given and instructions... Fall screen completed and the following interventions put into place: enlist family support and participation, assess Resident's room for pathway obstructions from bed to bathroom, validate call system knowledge and re-instruct as needed, encourage participation in daily activity programs, ensure Resident has appropriate footwear, and assist with toileting."<br><br>By observation on 11/05/14 at 11:30am, #189 | S3155 | | |

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| S3155 | Continued From page 16 | S3155 | | |

accompanied by staff to the bathroom, used walker, and received toileting task assistance.

By interview on 11/05/14 at 11:30am, Certified staff #J stated #189 receives help with showering, toileting, and reminders for meals... can transfer self and use walker.

The FCS identified the resident at risk for falls and the Licensed nurse identified Resident #189 as a fall risk at time of admission based on the fall screen. The NSA/HSP lacked interventions to address the risk for falls.

For Resident #189, the Administrator failed to ensure the licensed nurse provided and coordinated the provision of necessary health care services for this Resident, when the licensed nurse failed to implement interventions to address fall risk.

- Review of record revealed #186 admitted to facility 6/11/14 with diagnoses of Generalized debilitation, Hypertension, and Parkinson's.

6/11/14 - FCS (functional capacity screen) assessed #186 as in need of supervision with bathing; independent with dressing, toileting, transfers, mobility, eating, medication and treatments, and identified falls/unsteadiness as a current or recent problem or risk.

6/11/14 NSA (negotiated service agreement)/HSP (health care service plan) documented #186 to have staff assistance with bathing, staff to enhance communication to assure Resident needs are being understood, and staff to observe Resident's condition every two hours... requires

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| S3155 | Continued From page 17<br>status checks due to a recent hospitalization, illness, history of falls, medication change, etc.<br><br>Resident Progress Notes (RPN) documented:<br><br>6/13/14 10:11 a.m. "Resident arrived at community on 6/11/14 at 3:00pm ... given lifeline pendant and instructed on use... Fall screen completed and the following interventions put into place: educate Resident and family on ways to prevent falls, validate call system knowledge, encourage participation in daily activities, and ensure Resident has proper footwear." by licensed nurse #F<br><br>7/09/14 6:17 p.m." on 7/9/14 at approximately 1:20pm care staff responded to lifeline... on kitchen floor... stated okay and no complaint of pain... assisted up notified family and physician... The following intervention put into place: Remind Resident to use walker" by licensed nurse #D<br><br>7/11/14 and 10/9/14 NSA/HSP documented #186 staff to continue assistance with bathing, enhancing communication; no long included status checks.<br><br>7/21/14 - 2:54 p.m. "staff responded to life line on 7/20/14 around 8:30pm ...on bathroom floor with walker on top of him/her... called the nurse and Resident stated had no signs or symptoms of pain or injury and did not hit head... staff to place non slip strips in front of sink..."<br><br>7/26/14 2:45 a.m. " fax sent to [physician]: Please note on 7/25/14 (no time) staff responded to | S3155 | | |

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| S3155 | Continued From page 18<br>lifeline... on floor... resident stated he/she lost balance trying to shut curtains, denies hitting head... nurse assessed and no injuries noted... assisted up 2:1... Intervention: encourage to ask for assistance when needed.." by licensed nurse #H<br><br>8/08/14 6:22 p.m. "Fax sent to [physician]: on 08/07/14 at approximately 1:50pm staff responded to lifeline... on the floor... stated lost balance and fell... denies hitting head... states is fine... nurse assessed and no injuries noted, no complaints of pain... assisted up 2:1... ambulate without any difficulties..." by licensed nurse #H.<br><br>8/18/14 9:34 a.m. "Fax sent to [physician]: on 8/17/14 at 7:30am ... staff responded to lifeline... on floor in kitchen... stated lost balance... nurse on duty came to assess... no pain/discomfort, denies hitting head... skin tear left hand...nurse administered first aid Fall screen completed and the following intervention put into place: remind Resident to use walker while in apartment." by licensed nurse #F.<br><br>9/2/14 1:26 a.m. " Fax sent to [physician]: on 9/01/14 at approximately 6:40am ...staff responded to lifeline... observed lying on floor next to bed... stated fell out of bed, denies hitting head... nurse assessed Resident and no injuries but complained of pain on backside... refuses hospital/treatment...assisted up 2:1... ambulates without difficulties. Intervention: arrange bed to accommodate side of bed normally slept on." by licensed nurse #H. | S3155 | | |

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| S3155 | Continued From page 19<br><br>10/09/14 Comprehensive plan documented care staff to remind and encourage resident to use pendant for any assistance needed.<br><br>10/14/14 NSA/HSP documented #186 documented staff to continue assistance with bathing, enhancing communication; added staff will provide supervision and/or cuing for transfers when needed; requires supervision with transfers and occasional physical assistance; will ring when assistance is needed.<br><br>10/14/14 Comprehensive Plan documented #186 included to use pendant if help needed for toileting; staff to assist with dressing twice daily; supervision and occasional physical assistance with transfers; staff to remind Resident to use pendant for any needed assistance<br><br>Resident progress notes:<br><br>10/16/14 - 10:50pm "found on floor... stated stepped out of shower backwards and slipped and fell on buttocks then hit head on shower chair...family refused emergency transport and neuro checks..."<br><br>Resident #186's FCS identified him/her at risk for falls; the Licensed nurse identified Resident #186 as a fall risk at time of admission based on the fall screen and the record documented multiple falls after admission. The NSA/HSP lacked interventions to address the risk for falls.<br><br>For Resident #186 the Administrator failed to ensure the licensed nurse provided and | S3155 | | |

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| S3155 | Continued From page 20<br>coordinated the provision of necessary health care services for this Resident, when the licensed nurse failed to implement interventions to address fall risk. | S3155 | | |
| S3250 SS=F | 26-41-105 (a) Resident Records<br>a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices.<br>(1) Designated staff shall maintain the record of each discharged resident who is 18 years of age or older for at least five years after the discharge of the resident.<br>(2) Designated staff shall maintain the record of each discharged resident who is less than 18 years of age for at least five years after the resident reaches 18 years of age or at least five years after the date of discharge, whichever time period is longer.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-105 (a)<br><br>The census equalled 88 the sample included six, five current Residents and one discharged Resident, with three focused reviews completed. Based on interviews and reviews of records, for three of six sampled (#185, #187 and #186) and for one of three focused review (#182), the Administrator failed to ensure the maintenance of a record for each Resident in accordance with acceptable standards of practice for nursing | S3250 | | |

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| S3250 | Continued From page 21 | S3250 | | |

documentation.

Findings included:

- Review of record revealed #187 admitted to facility 6/06/14 with diagnoses of Alzheimer's, Hypertension, Urinary tract infection, and Mood disorder.

10/02/14 FCS (functional capacity screen) recorded #187 in need of supervision with bathing, dressing, toileting; unable to perform medication and treatment management; impairment of short term memory, long term memory, decision making and memory recall; and identified wandering as a current or recent problem or risk.

10/02/14 NSA (negotiated service agreement)/health care service plan (HSP) documented staff to assist with bathing, hearing aides, medications, escort to and from meals/activities, occasional observations for safety and interactions with others; staff to observe condition every hour, status checks due to diagnosis of dementia.

Resident Progress Notes documented the following:

10/02/14 - 4:04pm "arrived to community at approximately 12:30pm... previously resided in Assisted Living and was recently at hospital... alert, oriented per his/her norm... has no wounds, no complaints of pain upon admission... Vitals are as follows: Blood pressure 130/84 Pulse 74 Respirations 18. Fall screen completed and the following interventions put into place: assess Resident's room for pathway obstruction from bed to bathroom, encourage participation in daily

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| S3250 | Continued From page 22<br>activities, and ensure Resident has proper footwear." by licensed nurse #D<br><br>Documentation failed to include a physical assessment and failed to record clinical aspects of Resident's "norm" in regard to orientation.<br><br>10/20/14 9:47 a.m. late entry created with effective date of 10/17/14 9:45 described a fall that occurred on 10/17 at approximately 11:15 a.m.: "At approximately 11:15am care staff went to check on Resident in his/her room... observed on the floor lying on right side... this nurse called to assess... Blood Pressure 132/86 Pulse 72 Respirations 20... was assisted up 2:1... Resident had no noted injuries at the time... Resident did complain of right arm pain... upon assessment Resident had good ROM (range of motion) in all extremities... Resident assisted with dressing, and ambulated to the dining room without difficulty... family and physician notified of incident... Fall screen and Amended NSA completed... the following interventions put into place: contact physician to obtain an order for Urinalysis with C&S if indicated." by licensed nurse #D<br><br>Documentation noted effective time of entry prior to the stated time of the fall. Documentation also lacked specific facts related to where in room Resident located, length of time Resident on the floor, and/or last observation of Resident; failed to record Resident's mental status, orientation level, and if Resident able to provide information; failed to describe process used to evaluate range of motion; failed to record location and extent details of right arm pain; failed to record details of needing to be dressed mid day; and failed to record the factors indicating a urine test needed for Resident discovered on the floor. | S3250 | | |

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| S3250 | Continued From page 23 | S3250 | | |

10/17/14 - 11:40 pm "Fax sent to physician... "Requesting/Reporting: Resident has had increased confusion for 2 days and just had a fall at approximately 11:20am. Can we have an order for a UA (urinalysis) with C&S (culture and sensitivity) if indicated?" by licensed nurse #D

Documentation failed to record findings of current problems and issues that indicated a urinalysis an effective intervention for fall management; lacked a descriptive assessment of "increased confusion for 2 days."

10/18/14 - 4:28pm - "This nurse called to Resident's room by certified staff and family... breathing was shallow, when talked with Resident... was mostly unresponsive... stated I'm sleeping, after 20 minutes of prompting, while talking with EMS (Emergency medical services), answering questions... urine was dark orange per family's comments... both ankles showed s/s (signs/symptoms) of 2+ edema... Baker-Wong scale shows s/s of distress or discomfort and/or pain, at 7-8/10. EMS transported to hospital per family's agreement..."

Documentation failed to describe "mostly unresponsive" and failed to record a physical assessment of the resident.

On 11/05/14 at 3:04pm Assisted Living Care Coordinator #F and Life Guidance Care Coordinator #D stated an assessment/evaluation completed by LPN's (licensed practical nurses) when incidents/falls occur... stated they are checked to be sure not in pain... if obviously hit head, call EMS to do an assessment... if obvious injuries or Resident says they are injured we call EMS for an assessment... EMS does not give us

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| S3250 | Continued From page 24<br>documentation of their assessment... When asked what the LPN assessment/evaluation consists of, #F and #D stated we look for injury, blood, ask them to move extremities, make sure can move per their norm...no other documentation available.<br><br>For Resident #187, the Administrator failed to ensure the maintenance of a record in accordance with accepted professional standards and practices.<br><br>- Review of record revealed #185 admitted to facility 3/23/07 with diagnoses of Depression, Hypertension, Gastroesophageal reflux disease, Indigestion, Pain, Anxiety, Constipation, and Anemia.<br><br>8/13/13 - FCS (functional capacity screen) recorded #185 in need of physical assistance with bathing, dressing, toileting, transfers, mobility; use of wheelchair; experienced impaired short term memory and memory/recall; unable to perform medication and treatment management; with bladder incontinence, falls and unsteadiness.<br><br>10/21/14 and 7/23/14 - NSA (negotiated service agreement)/health care service plan (HSP) documented #185 to have staff assistance with bathing, dressing, medication/treatment management, toileting/incontinence; and escort or assist to/from meals.<br><br>10/21/14 and 7/23/14 - Comprehensive Plans - facility staff to assist with wheelchair mobility, bathing on Fridays, toileting, dressing, and medication assistance; encouraged to use call pendant if needs assistance transferring to | S3250 | | |

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| S3250 | Continued From page 25 | S3250 | | |

prevent falls; outside services by Hospice to include bathing each week; care staff will remind to use pendant to assist in the prevention of falls.

Resident Progress Notes (RPN) documented:

10/09/13 7:03 a.m. " on 10/9/13 at 3:30am staff responded to lifeline and noted resident sitting on floor at side of bed; stated he rolled out of bed; nurse on duty assessed... denies hit head, no complaints of pain.. .

10/9/13 7:03 a.m. entry also documented 2nd incident: "on 10/8/13 at 3:30 p.m. staff responded to lifeline and resident lying on back on floor next to bed with wheelchair over top of head and shoulders... trying to transfer self from wheelchair to bed and lost balance... denies hit head, no complaints of pain, assessed by nurse on duty...no injuries...

Documentation failed to include description of assessment made by nurse on duty and failed to identify the nurse completing the assessment.

10/22/13 1:27 a.m. "fax sent to [physician]: on 10/21/13 - 1045pm Resident pushed lifeline... care staff to assist... on floor by bed... stated bent down to get slippers and slid out of chair... nurse on duty to assess... denies hit head, no complaints of pain, assisted up 2:1.." by licensed nurse #F

Documentation failed to include description of assessment made by nurse on duty and failed to identify the nurse completing the assessment.

3/14/14 4:27 p.m. "Fax sent to [physician]: on

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| S3250 | Continued From page 26<br><br>3/12/14 - 7:20am care staff in apartment assisting Resident up for the day... resident sitting on side of bed... stood up, feet slid... hit head on wooden chair beside bed... nurse came to assess and EMS (Emergency Medical Services) assessed... Resident and DPOA (durable power of attorney) refused EMS... :by licensed nurse #F<br><br>Documentation failed to include an entry at the time of the incident including a description of assessment and findings made by nurse on duty and failed to identify the nurse who completed the assessment.<br><br>4/6/14 9:49 a.m. "Fax sent to [physician]: on 4/05/14 - 5:00pm Resident pushed lifeline... care staff to assist... on floor next to bed... trying to transfer self from recliner to wheelchair and feet got caught... denies hit head, no complaints of pain, assisted up 2:1...by licensed nurse #H<br><br>Documentation failed to include assessment by nurse.<br><br>4/10/14 7:12 p.m. "Fax placed in [physician's] folder: note on 4/09/14 - 6:00pm Resident pushed lifeline... care staff to assist... on floor next to bed... trying to transfer self from bed to wheelchair and slid out of bed... denies hit head, no complaints of pain, assisted up 2:1... by licensed nurse #H<br><br>Documentation failed to include assessment by nurse.<br><br>5/3/14 3:57 p.m. "Fax placed in [physician's] folder: on 5/03/14 - 2:15pm Resident pushed | S3250 | | |

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| S3250 | Continued From page 27<br>lifeline... care staff to assist... on floor next to bed... trying to transfer self from wheelchair to bed and slid out of bed... denies hit head, no complaints of pain, assisted up 2:1..." by licensed nurse #H<br><br>Documentation failed to include assessment by nurse.<br><br>6/1/14 3:31 p.m. "Fax placed in [physician's] folder: on this date at approximately 10:00am Resident pushed lifeline... care staff to assist... on floor next to bed... trying to transfer self from wheelchair to bed and slid out of bed... denies hit head, no complaints of pain, assisted up 2:1...by licensed nurse #H<br><br>Documentation failed to include assessment by nurse.<br><br>6/22/14 1:43 p.m. "Fax placed in [physician's] folder: on 6/20/14 - 11:20pm Resident pushed lifeline... care staff to assist... on floor next to bed... trying to transfer self from wheelchair to bed and slid out of bed... denies hit head, no complaints of pain, assisted up 2:1.."by licensed nurse #H<br><br>Documentation failed to include an entry at the time of the incident including an assessment by the nurse.<br><br>7/26/14 1:18 a.m. "Fax placed in [physician's] folder: on 7/23/14 - 6:45am Resident pushed lifeline (pendant), care staff to assist... on floor next to bed... stated fell out of bed, denies hitting head, no complaints of pain... assisted up 2:1 into | S3250 | | |

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| S3250 | Continued From page 28 | S3250 | | |

bed... "Intervention: Resident to use pendant prior to getting out of bed"...by licensed nurse #H

Documentation failed to include an entry at the time of the incident including an assessment by the nurse.

9/1/14 4:56 p.m. "Fax placed in [physician's] folder: on 8/01/14 [note: correct date is 9/1/14] - 0545 CMA (certified medication aide) entered room for medication administration and found resident on floor... did not know how he/she got there... nurse notified, no injuries noted... assisted 3:1 into wheelchair..." by licensed nurse #F

Documentation failed to include description of assessment made by nurse on duty and failed to identify the nurse completing the assessment.

For Resident #185, the Administrator failed to ensure the maintenance of a record in accordance with accepted professional standards and practices.

- Review of record revealed #186 admitted to facility 6/11/14 with diagnoses of Generalized debilitation, Hypertension, and Parkinson's.

6/11/14 - FCS (functional capacity screen) assessed #186 as in need of supervision with bathing; independent with dressing, toileting, transfers, mobility, eating, medication and treatments, and identified falls/unsteadiness as a current or recent problem or risk.

10/14/14 NSA (negotiated service agreement)/health care service plan (HSP)

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| S3250 | Continued From page 29 | S3250 | | |

documented #186 to have staff assistance with bathing and dressing; staff will work to enhance communication; staff will provide supervision and/or cuing for transfers when needed; requires supervision with transfers and occasional physical assistance; will ring when assistance is needed.

10/14/14 Comprehensive Plan documented #186 to have staff assistance with bathing; to use pendant if help needed for toileting; dressing; supervision and occasional physical assistance with transfers; staff to remind Resident to use pendant for any needed assistance

Resident Progress Notes (RPN) documented the following:

7/09/14 - 6:17 p.m. "On 7/6/14 at approximately 1:20pm care staff responded to lifeline... resident on kitchen floor laying on his/her right side, with his/her walker behind him/her... stated okay and no complaint of pain... assisted up notified family and physician... " by licensed nurse #D.

Documentation failed to include to include an entry at the time of the incident including an assessment by the nurse.

7/21/14 2:54 p.m. "Staff responded to lifeline around 8:30pm on 7/20/14. . resident found on bathroom floor on right side with walker on top of him/her... staff called the nurse and Resident stated had no signs or symptoms of pain or injury and did not hit head... "

Documentation failed to include an entry at the time of the incident including identification of the nurse contacted, instructions provided to staff or

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| S3250 | Continued From page 30<br>an assessment by the nurse.<br><br>7/26 2:45 a.m. "Fax to [physician]: note on 7/25/14 (no time) staff responded to lifeline... on floor... lost balance trying to shut curtains, denies hitting head... nurse assessed and no injuries noted... assisted up 2:1... by licensed nurse #H<br><br>Documentation failed to include an entry at the time of the incident, the time the incident occurred, description of the nursing assessment and identification of the nurse completing the assessment.<br><br>8/8/14 6:22 p.m. "Fax sent to [physician]: note on 8/07/14 at approximately 1:50pm staff responded to lifeline... on the floor... stated lost balance and fell... denies hitting head... states is fine... nurse assessed and no injuries noted, no complaints of pain... assisted up 2:1... ambulate without any difficulties...by licensed nurse #H<br><br>Documentation failed to include an entry at the time of the incident, description of the nursing assessment and identification of the nurse completing the assessment.<br><br>8/18/14 9:34 a.m. "Fax sent to [physician]: on 8/17/14 - 7:30am ... staff responded to lifeline... on floor in kitchen... stated lost balance... nurse on duty came to assess... no pain/discomfort, denies hitting head... skin tear left hand...nurse administered first aide." by licensed nurse #F<br><br>Documentation failed to include an entry at the time of the incident, description of the nursing assessment including a description of the skin | S3250 | | |

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| S3250 | Continued From page 31<br>tear and treatment administered and identification of the nurse completing the assessment.<br><br>9/2/14 1:26 a.m. "Fax sent to [physician]: on 9/01/14 at approximately 6:40pm ...staff responded to lifeline... observed lying on floor next to bed... stated fell out of bed, denies hitting head... nurse assessed Resident and no injuries but complained of pain on backside... refuses hospital/treatment...assisted up 2:1... ambulates without difficulties. " by licensed nurse #H.<br><br>Documentation failed to include an entry at the time of the incident, description of the nursing assessment including a specific location and assessment of pain, and identification of the nurse completing the assessment.<br><br>10/16/14 - 10:50pm "found on floor... stated stepped out of shower backwards and slipped and fell on buttocks then hit head on shower chair...family refused emergency transport and neuro checks..."<br><br>Documentation failed to include the time of the incident (recorded on incident report at 9:20 p.m.) or a physical assessment of Resident's condition, and failed to identify who assessed Resident.<br><br>By interview on 11/05/14 at 3:35pm Assisted Living Care Coordinator #F stated according to the above entries from record, I do not know which nurse completed the referenced documentation... when an incident/fall occurs, our staff would "evaluate" and call EMS, then EMS | S3250 | | |

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| S3250 | Continued From page 32 | S3250 | | |

would "assess"... when I go in I ask if any pain anywhere and if they hit their head... if they do have pain or hit head I call EMS... EMS doesn't give us their notes... no other documentation...

For Resident #186 the Administrator failed to ensure the maintenance of a record in accordance with accepted professional standards and practices.

- Review of record revealed #182 admitted to facility 12/04/12 with diagnoses of Alzheimer's dementia, Depression, and Hypertension.

The 6/21/14 FCS (functional capacity screen) assessed #182 in need of physical assistance with bathing, dressing, toileting, and eating; in need of supervision with transfers and mobility; unable to perform medication and treatments; with impaired communication, incontinence, short term memory, long term memory, memory recall, decision making, with falls/unsteadiness, and used a wheelchair.

The 5/20/14 NSA (negotiated service agreement)/health care service plan (HSP) documented #182 to receive staff assistance with grooming, bathing, dressing, eating, medications, incontinence care, escort to meals, and status checks hourly.

Resident Progress Notes included the following:

6/22/14 - 12:44 pm " Fax placed in physician's folder pertaining to: on 6/20/14 at approximately 7:30pm, staff observed #182 sitting on the floor in the hallway... nurse assessed and no apparent injuries noted.. denies hitting head and no

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| S3250 | Continued From page 33<br>complaint of pain... assisted up 2:1 and helped back to room... by licensed nurse #D<br><br>Documentation failed to include to include an entry at the time of the incident, description of the nursing assessment and identification of the nurse completing the assessment.<br><br>7/08/14 - 1:16 pm "Fax sent to physician: on 7/07/14 at approximately 6:45pm staff observed #182 sitting on the floor in the hallway... back against wall, walker off to the side... nurse on duty came to assess... #182 could not recall what happened... no complaint of pain or any other injuries noted at the time... assisted up 2:1... back to apartment with walker and stand by assistance... by licensed nurse #D<br><br>Documentation failed to include an entry at the time of the incident, description of the nursing assessment and identification of the nurse completing the assessment.<br><br>7/13/14 - 11:40am "Fax placed in physician's folder pertaining to: on 7/11/14 at approximately 7:15pm, staff observed #182 sitting on the floor in the hallway... nurse assessed and no apparent injuries noted.. denies hitting head and no complaint of pain... assisted up 2:1 and helped back to room..."by licensed nurse #H<br><br>Documentation failed to include an entry at the time of the incident, description of the nursing assessment and identification of the nurse completing the assessment.<br><br>8/07/14 - 2:21pm " On 8/06/14 at approximately | S3250 | | |

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| S3250 | Continued From page 34<br><br>11:15am nurse on duty was walking down the hallway and hear a Resident yell out... entered #182's apartment... observed lying on floor... stated hurt everywhere... noted lacerations to forehead and bridge of nose... 911 called and EMS (emergency medical services) transported to hospital... returned at approximately 3:00pm... at approximately 11:30 pm care staff doing first walk through of 30 minute checks observed #182 on floor by recliner. care staff notified EMS for right hip pain upon ROM (range of motion) when Resident tried to move... returned today at approximately 12:45pm... by licensed nurse #D<br><br>Documentation failed to include an entry at the time of the incident, description of the nursing assessment at the time of the incident and when the resident returned from the hospital and identification of the nurse completing the assessment.<br><br>8/18/14 - 10:09am "On 8/17/14 staff found Resident sitting on the ground in the patio area... stated did not hit head... charge nurse notified and assessed Resident... a small red area noted on Resident's back..."<br><br>Documentation failed to include the time of the incident, an entry at the time of the incident, description of the nursing assessment including a description of the injury and identification of the nurse completing the assessment.<br><br>8/18/14 - 11:36am - Staff found Resident sitting on the floor by closet door... stated did not hit head or hurt anywhere... nurse on duty assessed... " | S3250 | | |

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| S3250 | Continued From page 35<br><br>Documentation failed to include the time of the incident, description of the nursing assessment and identification of the nurse completing the assessment.<br><br>8/24/14 - 10:00am "Fax sent to [physician]: please note on 8/22/14 at approximately 7:30pm found Resident on floor in the bathroom doorway... when asked what happened there was no response... was moving around trying to get up and bleeding from left eyebrow... called EMS, family notified... admitted for left frontal lobe bleed...<br><br>Documentation failed to include an entry at the time of the incident, description of the nursing assessment at the time of the incident, and identification of the nurse completing the assessment.<br><br>Entries of 8/26/14 recorded Resident in the hospital... an entry dated 8/30/14 stated Safety committee met to discuss falls of #182, Resident currently in Hospice facility... no additional entries noted. The medical record failed to document the date and time of discharge for #182.<br><br>On 11/05/14 at 12:18pm, Life Guidance Care Coordinator #D and Administrator confirmed no discharge date, time, or information documented in the medical record, in accordance with accepted standards of practice.<br><br>For Resident #182 the Administrator failed to ensure the maintenance of a record in accordance with accepted professional standards | S3250 | | |

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| S3250 | Continued From page 36<br>and practices. | S3250 | | |